DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 Governors Drive
Pierre, South Dakota 57501-2291
(605) 773-3495
FAX (605) 773-5246
medical@state.sd.us
www.state.sd.us/social/medical/provider

Diabetes Management Education Program
Provider Enrollment Application Date:_____

To enroll in the South Dakota Diabetes Education Program as a Medicaid provider, this application must be completed. It contains questions to be answered completely and indicates other required documentation which must be submitted with enrollment forms.

Provider Name:_____

Facility Name:_____

Please check all that apply: _____**New Enrollment**

_____**Reinstate** _____**Reinstate Date**

_____**Federal Tax ID Number Change**

1. What hospital / clinic Medicaid Provider are you affiliated with?_____
2. What is your Medicare number?_____
3. What is your National Provider Identification Number (NPI)?
   Individual NPI_____
   Individual Sub NPI_____
   Other NPI_____Address Location_____
   Other NPI_____Address Location_____
4. List all Taxonomy Codes associated with enrolling provider.
   _____
   _____
5. What is the Federal Tax Identification Name and Number (TIN) used for billing purposes?
   _____
6. What is your provider type and specialty (i.e. physician, internal medicine / hospital, psychiatric)?
   _____
7. Where will the medical services be provided (i.e. hospital, clinic, school, rehab facility)?
   _____
8. What is the facility's laboratory CLIA number?_____

9. What is the service location name, address, and phone number?

Name:_____

Address:_____

City-State-Zip:_____

Phone Number:_____

Fax Number:_____

Contact Person:_____E-mail_____

10. What is the "pay to" location (address where payment will be sent)?

Name:_____

Address:_____

City-State-Zip:_____

Phone Number:_____

Fax Number:_____

Contact Person:_____E-mail_____

11. What is the billing location? Will you bill/process claims for enrolling provider? _____

Name:_____

Address:_____

City-State-Zip:_____

Phone Number:_____

Fax Number:_____

Contact Person:_____E-mail_____

12. When does billing location fiscal year end?_____

Also enclosed is the *South Dakota Medical Assistance Program Provider Agreement*. Please complete, sign, and return the agreement and this application along with requested information/documentation to:

Provider Enrollment
Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, South Dakota 57501-2291

Please enclose a copy of your current American Diabetes Association Certificate or South Dakota Department of Health Recognition Letter. Please enclose a copy of all current licensure applicable showing expiration date and current W-9 (revised 11-2005). A stamped signature or office manager's signature is not acceptable. An original signature is required.

Upon receipt of all necessary information, a determination will be made regarding your qualifications as a provider under the South Dakota Medical Assistance Program. When determination has been made a provider number will be assigned to you and a copy of the agreement returned to you for your files.

Thank you in advance for your assistance in this matter.